Handbook for Providers of Encounter Clinic Services

Chapter D-200 Policy and Procedures for Encounter Clinic Services

Illinois Department of Healthcare and Family Services

CHAPTER D-200

ENCOUNTER CLINIC SERVICES

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FOREWORD

PURPOSE

This handbook has been prepared for information and guidance for providers enrolled as an encounter clinic to provide primary care services to participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

This handbook can be viewed on the Department's Web site at

http://www.hfs.illinois.gov/handbooks/

This handbook provides information regarding specific policies and procedures unique to the encounter clinic program and this handbook is intended to be used in conjunction with Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Chapter A-200, Handbook for Physicians, HK-200, Handbook for Providers of Healthy Kids Services and Dental Office Reference Manual (DORM). The Handbook for Physicians includes policy guidelines and specific billing instructions applicable to providers of primary care services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's Web site

http://www.hfs.illinois.gov/releases/

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

CHAPTER D-200

ENCOUNTER CLINIC SERVICES

D-200 BASIC PROVISIONS

For consideration for payment by the Department to reimburse an encounter clinic, such services must be provided by a clinic enrolled in the Department's Medical Programs. The clinic must be certified as a Federally Qualified Health Center, a Certified Rural Health Clinic or an Encounter Clinic certified by the Department and eligible for an encounter rate. Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, General Policy and Procedures (Chapter 100) and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms. Providers submitting electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

The Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services survey and certify the Federally Qualified Health Centers and Rural Health Clinics as cost-based facilities.

- **Federally Qualified Health Center (FQHC)** - A health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Service Administration, U.S. Department of Health and Human Services.

- **Freestanding Rural Health Clinic (RHC)** - A health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) (42 USC 1395x(aa)(2)) to be an RHC.

- **Provider Based Rural Health Clinics (Provider Based RHC)** - A provider based Rural Health Clinic is an integral part of a hospital that is participating in the Medicare program and is licensed, governed, and supervised with other departments of the hospital.

- **Encounter Rate Clinic** - A clinic that was actively participating in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998, or a clinic operated by a county with a population of over three million.

Individual practitioners associated with any of the clinics may apply for participation in the Medical Assistance Program in their individual capacities.

D-201 PROVIDER PARTICIPATION

It is a requirement that each clinic enroll with the Department in order to be considered for reimbursement. If multiple sites are owned or operated by the same entity each site must be enrolled separately and all documents listed below provided for each site.

D-201.1 PARTICIPATION REQUIREMENTS

Clinics are eligible to be considered for enrollment to participate in the Department's Medical Programs.

Procedure: The provider must complete and submit:

- Form HFS 2243 (Provider Enrollment/Application)
- Form HFS 1413 (Agreement for Participation)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

hfs.PPU@illinois.gov

Providers may also call the unit at (217)782-0538 or mail a request to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
http://www.hfs.illinois.gov/enrollment/

=The following documentation must be provided with the application, if appropriate.

- CMS Grant Award Notice (FQHCs)
- Clinical Laboratory Improvement Amendments of 1988 Certificate
- Copy of Clinical Psychologist, Clinical Social Worker or Clinical Professional Counselor license
- Letter of effective date for behavioral health services
- Copy of a current collaborative or written practice agreement with a collaborating physician or practitioner under whom the APN will be practicing, as set forth in the Nursing and Advanced Practice Nursing Act.

Special Dental Enrollment Criteria - The following documentation must be provided with the application. A letter from the clinic informing the Department of the dental clinic name and medical number of the site that will be providing dental services and the projected begin date. Attachments to the letter should include:

Existing Site Enrollment

- Copy of Health Resources and Services Administration (HRSA) Form 5 - Part A Services Provided,
- Copy of the CMS Notice of Grant award,
- Copy of Exhibit B Service sites, and
- Names of dentists providing dental services.

New Site Enrollment

- Copy of the HRSA scope of project application submitted to CMS,
- Copy of the CMS Notice of Grant award,
- Copy of HRSA Form 5 - Part A Services Provided,
- Copy of Exhibit B Service sites, and
- Names of dentists providing dental services.

The forms must be completed (**printed** in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Change in Ownership or Corporate Structure - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation and other necessary documents must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

D-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix D-2.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic D-201.4.

D-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

D-201.4 PROVIDER FILE MAINTENANCE

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

D-202 CLINIC REIMBURSEMENT

D-202.1 CHARGES

Providers may only bill the Department **after** the service or item has been provided. The clinic will be reimbursed at the all inclusive rate per encounter established by the Department.

D-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services, which do not require attachments or accompanying documentation, may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

D-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services, refer to Appendix D-1a.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix D-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for

evaluation to the following address.

Healthcare and Family Services 201 South Grand Avenue East Second Floor - Data Preparation Unit Springfield, Illinois 62763-0001 Attention: Vendor/Scanner Liaison

D-202.31 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form HFS 1444, Provider Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use Form HFS 1414, Special Approval Envelope. A non-routine claim is:

- Any claim to which Form HFS 1411, Temporary MediPlan Card, is attached.
- Any claim to which any other document is attached.

For electronic claims submittal, Refer to Topic D-202.2 above. Non-routine claims may not be electronically submitted.

D-202.4 PAYMENT

Payment made by the Department for allowable services will be made at the all inclusive rate per encounter established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

D-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services. Those core services for which the clinic may bill a medical encounter are as follows:

- Physician's services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants.
= • Other services for which a separate encounter may be billed include dentist and behavioral health services defined as licensed clinical psychologist, licensed clinical social worker or licensed clinical professional counselor services.
- Preventative Services
  - required school examinations for children;
  - periodic well-child services (visits, immunizations and screenings) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program;
  - preventive services for adult participants, age 21 and older;
  - Cancer screenings.
- A FQHC may provide pharmaceutical services and supplies to participants if enrolled separately with the department as a participating pharmacy licensed to provide pharmaceutical services to the general public (Division 5 license).

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

D-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Preventive services are not covered, except for required school examinations for children, periodic well-child visits under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program and those preventive services specifically designated as covered in the Handbook for Physicians, Chapter A-200 or in other written communications from the Department. Refer to Chapter 100, Topic 104, for a general list of non-covered services.

Medically necessary services and supplies included in the cost report, furnished by or under the direction of a physician or dentist within the scope of licensed practice, may not be billed fee-for-service or as an encounter. Some examples of these services include:

- medical case management;
- laboratory services;
- occupational therapy;
- patient transportation;
- pharmacy services;
- physical therapy;
- podiatric services;
- speech and hearing services;
- X-ray services;
- health education;
- nutrition services;
- optometric services;
- chiropractic services.

D-205 RECORD REQUIREMENTS

The Department considers the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the health care provider rendering services.

The record maintained at the clinic is to include the essential details of the patient's condition and of each service provided. Any services provided a patient outside the clinic must be documented in the medical record maintained at the clinic. All entries must include the date and must be legible and in English. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition and treatment and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the clinic as an office record to show continuity of care.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

D-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES

The same policy and procedures that apply to physicians also apply to the encounter clinics. Refer to the Handbook for Physicians for detailed department policy regarding primary care.

In addition to the appropriate encounter code, all encounter clinics must **detail all services provided during the encounter** using the appropriate CPT or HCPCS procedure codes. Any claims received without detailed services will be rejected.

D-210.1 DEFINITION OF ENCOUNTER

= A billable encounter is defined as a face-to-face visit with a physician, physician assistant, midwife or nurse practitioner or, if the FQHC or RHC is enrolled to provide dental or behavioral health services, a dentist, licensed clinical psychologist, licensed clinical social worker or licensed clinical professional counselor, as applicable. Only services provided at the sites approved by HRSA in the FQHC Scope of Service, RHC site or the patient's place of residence are billable as an encounter. The face-to-face visit and all other ancillary services provided on a specific date of service will be reimbursed by the Department at the FQHC's or RHC's applicable (medical, dental or behavioral health) encounter rate.

If the service provided to a patient does not meet the definition of a billable encounter, no reimbursement can be made by the Department.

D-210.2 MEDICAL SERVICE ENCOUNTER

An FQHC or RHC may bill only one (1) medical encounter per patient per day and, if enrolled with the Department to provide dental services, one (1) dental encounter per patient per day. FQHCs and RHCs who enroll with the Department to provide behavioral health services may, in addition, bill one (1) behavioral health encounter per patient per day.

D-214 COST REPORTS

Once an FQHC/RHC has been accepted as an enrolled provider, yearly filings of the cost report and supporting documents are mandatory. If the required cost report and supplemental documents are not submitted within the required time limit, the Department will suspend payments to the FQHC/RHC. This action will remain in effect until proper submission of all the required documents. Each cost report is subject to audit by state auditors to determine proper costs. If the cost data from the cost reports is not traceable to the supplemental documents, an onsite audit will be made to determine if the clinic is eligible to continue in the FQHC/RHC program. FQHC/RHC Cost Reports must be completed by each FQHC/RHC operating a clinic in the State of Illinois and seeking payment under the provisions for FQHC/RHCs. If an FQHC/RHC within Illinois has several clinic sites, it may choose to either file one (1) cost report covering all clinic sites or file individual cost reports for each clinic site operated by the FQHC/RHC. FQHC/RHCs in contiguous states must file an Illinois cost report and audited financial statement for clinics they operate which serve Illinois patients.

The FQHC/RHC must maintain financial and clinical records which are accurate and in sufficient detail to substantiate the cost data reported for a period of no less than three (3) years. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC/RHC or they will be disallowed.

D-214.1 FILING OF THE COST REPORT

Federally Qualified Health Center

The FQHC must file with the Department a completed cost report and audited financial statements annually within one hundred eighty (180) days after the close of the Center's fiscal year. An FQHC cost report may be filed more often or less often than an annual period only when necessitated by the facility terminating its agreement with the Department, by a change in ownership, or by a change in fiscal period.

Improperly completed or incomplete filings will be returned to the facility for proper completion and must be resubmitted to the Department within thirty (30) days.

Each required FQHC Cost Report must be signed by the authorized individual who normally signs the FQHC's federal income tax return or similar reports. The person preparing the FQHC Cost Report must also sign the report and list his/her telephone number.

FQHC Cost Reports must be prepared in conformance with generally accepted accounting principles and the provisions of the Federally Qualified Health Center

Accounting Requirements. Cost reports must be filed using the accrual method of accounting.

Provider-Based Rural Health Center and Freestanding Rural Health Center

All RHCs must submit an annual cost report for their fiscal year within one hundred eighty (180) days after the close of the Center's fiscal year.

Free-Standing Rural Health Centers:
The cost reporting responsibility can be met by submittal of a copy of the cost report form (CMS 222-92) that was filed for the Medicare program. Additionally, the RHC must file two (2) Medicaid attachments to provide additional details regarding some cost categories.

Provider-Based Rural Health Centers:
The cost reporting responsibility can be met by submittal of a copy of the cost report form (Medicare worksheet M series) that was filed for the Medicare program. Additionally, the RHC must file two (2) Medicaid attachments to provide additional details regarding some cost categories.

D-214.2 REASONABLE COSTS - FQHC

The Department will determine if costs are reasonable and allowable by applying Medicare cost reimbursement principles, as defined by federal regulation at 42 CFR, Section 413, the Social Security Act, Section 1861 (V), or as modified by the Department.

Reasonable costs of any service are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable costs takes into account both direct and indirect costs of providers of services, including normal standby costs.

Costs may vary from one institution to another because of scope of services, level of care, geographic location and utilization. It is the intent of the program that clinics will be reimbursed the current actual costs of providing high quality care, regardless of how widely they may vary from clinic to clinic, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization and other relevant factors. "Utilization" for this purpose refers not to the clinic's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix, age of patients, type of illness, etc.).

D-214.3 REIMBURSABLE COSTS

Costs related to patient care include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the clinic's activity. This includes personnel costs, administrative costs and others. Allowance of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

D-214.4 NON-REIMBURSABLE COSTS

Clinic services and cost not reimbursable by the Department.

Women, Infant and Children (WIC) Program and Nutritional Services
Any costs related to the WIC Program or professional services provided by a clinic nutritionist are not reimbursable by the Department. These costs must be reported on the non-reimbursable section of the cost report.

Costs Not Related to Patient Care
Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of the patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals to visitors; costs of drugs sold to other than patients; cost of operation of a gift shop; non-covered services that are provided; and similar items.

D-215 AUDIT OF COST REPORTS

All cost reports submitted require a desk audit. If further information or documentation is required, a field audit may be required.

D-215.1 DESK AUDIT

The desk audit includes procedures that will:

- verify the completeness and mathematical accuracy of all schedules in the report,
- compare reported program statistics with the Department's payment data,
- identify the need for supporting documentation and arrange to receive such documentation,
- compare reported data with industry norms as an aid to the audit scope determination, and
- identify the need for a field audit examination and possible rate adjustment.

D-215.2 FIELD AUDIT

Field audits are performed, if necessary, in accordance with the Federal Department of Health and Human Services requirements for federal participation and include appropriate auditing procedures and techniques as are deemed necessary by the Department. The scope of the field audit will be sufficiently comprehensive to verify that in all material respects reported data is documented by supporting records and that the costs are allowable pursuant to Medicare cost reimbursement principles. If direct expenses and allocated expenses cannot be documented, they will not be allowed.

D-216 RATE SETTING

Rates will be based on a prospective payment system. For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs with similar caseloads, as determined by the Department. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter Statewide for all FQHCs or RHCs, as the case may be.

D-217 RATE APPEALS

FQHCs have the right to appeal audit adjustments or rate determinations.

Appeal Process

- All appeals must be submitted in writing to the Department. Appeals submitted within sixty (60) calendar days of the rate notification, if upheld, shall be made effective as of the beginning of the rate year.
- To be accepted for review, the written appeal must include:
  - The current approved reimbursement rate, allowable costs and the additional reimbursable costs sought through appeal.
  - A clear, concise statement of the basis for the appeal.
  - A detailed statement of financial, statistical and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement.
  - A statement by the provider's Chief Executive Officer or Chief Financial Officer that the application of the rate appeal and information contained in the vendor's reports, schedules, budgets, books and records submitted are true and accurate.
- Rate appeals may be considered for the following reasons:
  - Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable cost.
  - Mechanical or clerical errors committed by the Department in auditing historical expenses as reported or in calculating reimbursement rates.

The Department shall rule on all appeals within one hundred twenty (120) calendar days of receipt of the appeal except that, if additional information is required from the facility, the period shall be extended until such time as the information is provided. Appeals must be submitted to the following address:

Healthcare and Family Services
Office of Health Finance
201 South Grand Avenue East
Springfield, Illinois 62763-0001